NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE
NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by NYS disability and Paid Family Leave benefits carrier or licensed insurance agent of that carrier

1a. Legal Name & Address of Insured (use street address only)	1b. Business Telephone Number of Insured
FINGER LAKES INDEPENDENCE CENTER, INC. 215 FIFTH STREET ITHACA NY 14850 Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)*	607-272-2433 1c. Federal Employer Identification Number of Insured or Social Security Number 16 1330345
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) NY STATE EDUCATION DEPT 89 WASHINGTON AVE ALBANY NY 12234	3a. Name of Insurance Carrier **The Guardian Life Insurance Company of America** 3b. Policy Number of Entity Listed in Box 1a 0926325-0000 3c. Policy Effective Period 07/01/2024 to 07/01/2025

4. Policy provides the following benefits:
   - [x] A. Both disability and Paid Family Leave benefits.
   - [ ] B. Disability benefits only.
   - [ ] C. Paid Family Leave benefits only.

5. Policy covers:
   - [x] A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.
   - [ ] B. Only the following class or classes of employer's employees:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS disability and/or Paid Family Leave benefits insurance coverage as described above.

Date Signed 08/21/2024 By MrPr

(Signature of insurance carrier's authorized representative or NYS licensed insurance agent of that insurance carrier)

Telephone Number 1-888-278-4542 Name and Title Michael Prestileo, Head of Group Benefits Strategy, Product & Underwriting

IMPORTANT: If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.

If Box 4B, 4C or 5B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Paid Family Leave Benefits Law. It must be emailed to PAU@wcb.ny.gov or it can be mailed for completion to the Workers' Compensation Board, Plans Acceptance Unit, PO Box 5200, Binghamton, NY 13902-5200.

PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4B, 4C or 5B have been checked)

State of New York
Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability and Paid Family Leave Benefits Law(Article 9 of the Workers' Compensation Law) with respect to all of their employees.

Date Signed _____ By _____

(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number _____ Name and Title _____

Please Note: *Only insurance carriers licensed to write NYS disability and Paid Family Leave benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1.* ***Insurance brokers are NOT authorized to issue this form.***

NYSIF
New York State Insurance Fund

PO Box 66699, Albany, NY 12206
| nysif.com

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE (RENEWED)

^ ^ ^ ^ ^ ^ 161330345
FINGER LAKES INDEPENDENCE
CENTER INC
215 FIFTH ST
ITHACA NY 14850

SCAN TO VALIDATE
AND SUBSCRIBE

POLICYHOLDER	CERTIFICATE HOLDER
FINGER LAKES INDEPENDENCE CENTER INC 215 FIFTH ST ITHACA NY 14850	NY STATE EDUCATION DEPT 89 WASHINGTON AVE ALBANY NY 12234

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
E1326 591-3	954653	07/01/2024 TO 07/01/2025	7/9/2024

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1326 591-3, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP. THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 692381199

U-26.3